be considered as members of the applicable "Southern Florida Counties" size class in the patient care cost component until such time as the "Central Florida Counties" patient care cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" patient care cost component ceiling.

B. Setting prospective reimbursement per diems and ceilings. In determining the class ceilings, all calculations for Sections V.B. 1. - V. B. 18. shall be made using the four class, and "Northern Florida Counties" and "Southern Florida Counties" definitions of sections V.A. 2. above. All calculations for Sections V.B.19. - V.B.21 shall be made using the six class and "Central Florida Counties" definition of Section V.A.3. above. The Agency shall:

1. Review and adjust each provider's cost report referred to in A.l. to reflect the result of desk or on-site audits, if available.

2. Reduce a provider's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30

3. Determine total allowable Medicaid cost.

4. Determine allowable Medicaid property costs, operating costs, patient care costs, and return on equity or use allowance. Patient care costs include those costs directly attributable to nursing services, dietary costs, activity costs, social services costs, and all medically ordered therapies. All other costs, exclusive of property cost and return on equity or use allowance costs, are considered operating costs. For providers receiving FRVS payments, the return on equity cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a return on equity for property assets as per Section III.J. and K.

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a. Effective January 1, 2002, there will be direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Providers will be required to complete a supplemental schedule for the Medicaid cost report to be used in the January 1, 2002 rate setting. The supplemental schedule shall contain the direct subcomponent of the patient care costs. Providers who do not submit a supplemental schedule shall have all patient care costs allocated into direct care and indirect care subcomponents based on a 65% and 35% split, respectively. Providers who do not submit the supplemental schedule will be excluded from the calculation of patient care ceilings.

Providers who do not submit the supplementary schedule will not have their costs "grossed-up," as detailed in b. below, if their staffing ratios do not meet the mandated minimum staffing standards for January 1, 2002. For providers filing a late supplemental schedule, there will be no retroactive adjustment to direct care or indirect care allocation or to the "gross-up." The late-filed supplemental schedule will not be used until the following prospective January 1 and July 1 rate semesters.

b. For the January 1, 2002 rate semester, each prospective provider's direct care subcomponent will be adjusted for the additional costs incurred by the provider to comply with the minimum staffing requirements for nursing (registered nurses and licensed practical nurses) and certified nursing assistants (CNA's). This adjustment will be based on the information provided by each provider in the supplemental schedule filed with the cost report used to establish the January 1, 2002 Medicaid per diem rate.

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The total reported productive hours for registered nurses (RN), licensed practical nurses (LPN), and CNA's will each be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will represent the hours per patient day for each level of nursing service. The productive hours per patient day for RN's and LPN's will be combined for total productive nursing hours per patient day. Gross-up factors will be calculated for nursing hours and CNA hours by dividing the productive nursing hours per patient day into 1.0 and dividing the productive CNA hours per patient day into 2.3. Facility direct care subcomponent nursing costs will be multiplied by the nursing gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. Facility direct care CNA cost will be multiplied by the CNA gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. These adjusted nursing and CNA costs will be added together to obtain the adjusted direct care costs.

The adjusted direct care costs will be used for the purpose of computing ceilings and the prospective per diem rate.

c. Beginning with the January 1, 2003 rate semester, each prospective provider's direct care subcomponent for nursing (registered nurses and licensed practical nurses) will be adjusted based on the information provided by each provider in the supplemental schedule filed with the cost report used to establish the January 1, 2003 Medicaid per diem rate. The total reported productive hours for registered nurses (RN) and licensed practical nurses (LPN) will be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result

will represent the hours per patient day for nursing service. The productive hours per patient day for RN's and LPN's will be combined for total productive nursing hours per patient day. Gross-up factors will be calculated for nursing hours by dividing the greater of nursing hours per patient day or the weighted minimum requirement for the cost reporting period (weighted by days) into 1.0. The nursing weighted minimum requirement shall be used for cost reports ending May 31, 2002 or later. The nursing weighted minimum requirement shall be weighted by days using .6 hours per patient day prior to January 1, 2002 and 1.0 hours per patient day after Janaury 1, 2002, using the time period defined in the cost report used to set the respective rate. Facility direct care nursing costs will be multiplied by the nursing gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. The gross-up factor will apply for all per diem rates using cost reports that include any costs incurred prior to January 1, 2002. All rates based upon cost reports that begin on or after January 1, 2002 will receive a gross-up factor of 1.0, as such cost reports will reflect full costs at the nursing staffing requirements post January 1, 2002.

Beginning with the January 1, 2003 rate semester, each prospective provider's direct care subcomponent will be adjusted for the incremental costs incurred by the provider to comply with the minimum staffing requirements for certified nursing assistants (CNAs). This adjustment will be based on the information provided by each provider in the supplemental schedule filed with the cost report used to establish the January 1, 2003 Medicaid per diem rate. The total reported productive hours for CNAs will be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will represent the hours per patient

day for CNA nursing service. Gross-up factors will be calculated for CNA hours by dividing the greater of hours per patient day or the weighted minimum requirement for the cost reporting period (weighted by month) into 2.6. The CNA weighted minimum requirement shall be used for cost reports ending May 31, 2002 or later. The nursing CNA weighted minimum requirement shall be weighted by days using 1.7 hours per patient day prior to January 1, 2002 and 2.3 hours per patient day after Janaury 1, 2002, using the time period defined in the cost report used to set the respective rate. Facility direct care CNA costs will be multiplied by the CNA gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0.

The adjusted direct care costs will be used for the purpose of computing ceilings and the prospective per diem rate.

5. Calculate per diems for each of these four cost components by dividing the components' costs by the total number of Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per Section V.E. of this plan.

6. Adjust a facility's operating and patient care per diem costs that resulted from Step B.5 for the effects of inflation by multiplying both of these per diem costs by the fraction: Florida Nursing Home Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Nursing Home Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Nursing Home Cost Inflation Index is displayed in Appendix A. Only providers being paid a prospective rate under section V.B.6. shall be eligible for the Medicaid Adjustment Rate (MAR) except for those providers defined in section I.B. of the Plan.

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7. Adjust, for those facilities not being paid under FRVS, all four components of the per diem for low occupancy per a. through g. below. For those facilities being paid under FRVS, adjust the operating cost component, the patient care cost component, and the return on equity or use allowance cost component, but do not adjust the property component for low occupancy.

   a. Calculate the percentage of occupancy for each facility.

   b. Calculate the mean and the standard deviation of the distribution of occupancy levels obtained in 7.a.

   c. Calculate the percentage of Medicaid days to total days for each facility ("percent Medicaid").

   d. Calculate the mean and the standard deviation of the distribution of percent Medicaid obtained in 7.c.

   e. Calculate the adjusted per diem components by multiplying each of the per diem components by the fraction: Individual facility occupancy level, divided by the statewide mean occupancy level less one standard deviation of occupancy levels from Step B.7.b.

   f. The adjustment described in e. above shall not apply to:

      1) Facilities with occupancy levels that exceed the statewide mean occupancy level less one standard deviation;

      2) Facilities with only one cost report filed.

      3) Facilities with a percentage of Medicaid days that exceeds the statewide mean less one standard deviation of the percentages of Medicaid days.

   g. The occupancy adjustment for operating and patient care costs shall not result in a reduction of more than 30 percent of the applicable class

ceiling. The property cost and return on equity or use allowance components shall be adjusted proportionately. The proportionate adjustment for the property and return on equity or use allowance per diems shall be made by multiplying each of those two per diems by the fraction:

The sum of the operating cost per diem, adjusted for occupancy, plus the patient care cost per diem, adjusted for occupancy; divided by the sum of the unadjusted operating cost per diem plus the unadjusted patient care cost per diem.

The property cost component shall not be subject to this low occupancy adjustment if a facility is being reimbursed under FRVS.

8. Determine the statewide property cost per diem ceilings for periods April 1, 1983 to July 1, 1985 as per a. through h. below.

a. Calculate the per diem property cost for the array of newly constructed facilities by dividing the total property cost by the total patient days for each facility.

b. Calculate the statewide average occupancy for all facilities used in setting the patient care and operating ceilings. Calculate the median occupancy for the array of newly constructed facilities.

c. Calculate two occupancy-adjusted property per diems:

(l) An average occupancy property per diem is calculated.

The average occupancy property per diem equals the newly constructed facility occupancy divided by the statewide average occupancy, times the newly constructed facility property per diem.

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(2) A median occupancy property per diem for newly constructed facilities is calculated as follows:

The median occupancy property per diem equals the newly constructed facility occupancy, divided by the median of newly-constructed facility occupancies, times the newly constructed facility property per diem.

d. Adjust the two occupancy-adjusted property per diems for the effects of construction cost inflation by multiplying each by the fraction: Florida Construction Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Construction Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Construction Cost Inflation Index is displayed in Appendix B.

e. Calculate the median and standard deviation of the distributions of average occupancy and median occupancy property per diems.

f. The statewide property cost per diem ceiling for facilities that have more than 18 months operating experience shall be the median of the average occupancy property per diems plus one standard deviation.

g. The statewide property per diem ceiling for facilities that have 18 or fewer months of operating experience shall be the median of the distribution of median occupancy property per diems plus one standard deviation. A facility which has more than 18 months operating experience shall be subject to a weighted average property ceiling at the addition of beds at 50 percent or more of the existing bed capacity, or the addition of 60 beds or more. A weighted average rate shall be computed, equal to the sum of:

1) Actual per diem costs of the original facility, limited by the lower property ceiling, multiplied by the ratio of its beds to total facility beds; and

2) Actual per diem costs of the addition, limited by the higher property ceiling, multiplied by the ratio of its beds to total facility beds.

This weighted average rate shall be effective for 18 months from the date the additional beds were put into service.

h. Facilities that are not reimbursed based on FRVS shall be subject to the property cost ceilings calculated at July 1, 1985. New property cost ceilings shall not be calculated at subsequent rate semesters.

9. Determine the median inflated operating and patient care costs per diems for each of the four-classes and for the whole State.

10. For each of the per diems in 9. above, calculate the ratios for each of the four class medians to the State medians.

11. Divide individual facility operating cost per diems and patient care cost per diems that resulted from Step B.7. by the ratio calculated for the facility's class in Step 10.

12. Determine the statewide median for the per diems obtained in Step B.11.

13. For each of the operating and patient care per diems, exclude the lower and upper 10 percent of the per diems of Step B.11. and calculate the standard deviation for the remaining 80 percent.

14. Establish the statewide cost based reimbursement ceiling for the operating cost per diem as the sum of the median plus one standard deviation and for the patient

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care cost per diem as the sum of the median plus 1.75 standard deviations that resulted from Steps B.12. and B.13., respectively.

15. Establish the cost based reimbursement ceilings for operating and patient care costs per diems for each class by multiplying the statewide ceilings times the ratios calculated for that class in Step B.10.

16. Effective July 1, 1996, except for: the January 1, 2000 rate semester for the patient care component and the July 1, 2002 and July 1, 2003 rate semesters for the operating component, establish the target reimbursement for operating and patient care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and patient cost in Step B.16 from the previous rate semester, excluding incentives and the Medicaid Adjustment Rate (MAR), with the quantity:

$$1 + 1.4 \times \frac{\text{Florida Nursing Home Cost Inflation Index (at the midpoint of the prospective rate period -1)}}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}}$$

In the above calculation the 1.4 shall be referred to as the inflation multiplier. For the January 1, 2000 rate semester only, the patient care component inflation multiplier in the above equation shall be adjusted upward for each provider until this adjustment in conjunction with the adjustment in B.17. c. results in an estimated additional reimbursement in the patient care component per B. 18. This adjustment in the inflation multiplier shall not result in a patient care per diem rate that exceeds the patient care per diem costs adjusted for inflation in Step B.6 or be less than a patient care per diem cost calculated using an inflation multiplier of 1.4.

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